Arizona Dept. of Health Services Division of Behavioral Health Services

Encounter Tidbits

Arizona Department of Health Services

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HIPAA Corner… … …

HIPAA Intake Processing Flow

Intakes will be submitted in HIPAA 834 format using the guidelines provided by ADHS/DBHS. The input INTAKE file name will be HINTKExx.darbha ("xx" represents the two-digit RBHA number used by DBHS). This file will be sent to the DBHS server, which has individual locations for FTP transfers for each RBHA and a location called RBHA_Common for files that apply to all of the RBHAs. Transactions will be accepted for translation any time up to the cut off of 6pm daily each workday.

During translation processing any error will result in the complete file being rejected. Two files will be created, one is the HINTKExx.error file, which is the original file, and the other is the HINTKExx.997 file that gives the reason for the errors. Both of these files will be returned to the DBHS server.

After translation the HINTKExx.darbha file will be named UINTKExx.darbha. This file is only used internally by DBHS in the normal daily processing. Output from the normal daily processing are three data files, one of accepted data and the other two of unaccepted data, all of which are provided to each RBHA via the DBHS server.

The accepted data file is named DINTDxx.dayyyymmdd.nn. In addition to this file, a report file is created for each RBHA, named UINTKExx.ctyyyymmdd.nn. The unaccepted data files are created for each RBHA and named UINTKExx.eryyyymmdd.nn and UINTEDxx.eryyyymmdd.nn.

In the event a RBHA needs to have a file of all intake data that is reflected on the DBHS system, such as for purposes of reconciliation or because of processing problems, a "resync" file containing all clients with an active status may be requested. The resync file will be named yymmdd FTPxxR12 M.

Responsibility for Out of Area Crisis

If a client has a crisis in another RBHA's area, the service must be provided in that area without regard to the person's enrollment status. It is then the responsibility of the home RBHA to pay for the service. A single case agreement may need to be done with the provider if the home RBHA does not already have a contract with them. If the provider bills the RBHA where the service was provided, that RBHA needs to immediately inform the provider that they need to bill the home RBHA for the service.

Edit Alerts

An Edit Alert is a faxed and e-mailed notice of system enhancements or changes. The Office of Program Support strives to ensure any system enhancements or changes are communicated to all program participants in an accurate and reliable manner. Edit Alerts will be distributed when the information is first made available and again with the following monthly publication of the Encounter Tidbits.

AHCCCS Edit Changes

Due to a recent problem in reported health plan paid amount, AHCCCS has made the decision to modify encounter errors A900/A901 Unreasonable Health Plan Paid Amount, to identify significant differences (±500% and ±250%, respectively) between the AHCCCS fee schedule and the health plan paid amount. AHCCCS is expected to change the edit status of A900 from soft to hard effective July 1, 2004. The A901 error may be changed to hard at a later date.

Diagnosis codes V71.09 and 799.9

There has been some controversy surrounding the use of ICD-9 diagnosis codes V71.09 and 799.9 when completing the Axis I & II fields on the assessment/demographic record. Currently, the Client Information System (CIS) has edits in place to deny the record when V71.09 and 799.9 are submitted in any Axis I & II fields. We will have this corrected, but for now, please continue to use the more definitive ICD-9 diagnosis codes in Axis I & II.

When our correction of the System is in place, you will be able to use ICD-9 codes V71.09 and 799.9 in any Axis I or II field when a more definitive diagnosis is not available. If either of these codes is used in Axis I, there must be a definitive diagnosis in Axis II. If either code is used in Axis II, there must be a definitive diagnosis in Axis I. If the V71.09 or 799.9 is the only diagnosis code in Axis I or II, it must be replaced with a more definitive diagnosis within 45 days. The above information refers to intakes *only*; you may not use these codes for encounters or claim submissions, with the exception of transportation claims. The RBHAs may continue to use ICD-9 code 799.9 for transportation claims and Non-Title XIX/XXI claims.

Intake Edits Update

The new intake edits are up and running. After a week of working out a few unexpected kinks, initial feedback indicates the edits are doing what they are supposed to be doing - helping to eliminate duplicate client IDs.

Flex Funds

Flex Funds, referred to in the Covered Services Guide as "Non-Medically Necessary Covered Services" procedure code S9986, are limited to $1,525.00 per *calendar* year per client. These funds are used to purchase a variety of one-time or occasional goods and/or services needed for enrolled persons and their families. Only when the goods and/or services cannot be purchased by any other funding source, and the service or good is directly related to the enrolled person's service plan. In consideration with other available resources, the clinical liaison and behavioral health representative on the team or service provider may approve flex fund expenditures as permitted by the T/RBHA up to the $1,525.00 maximum. If services are required beyond the $1,525.00 maximum, then the T/RBHA representative must contact Frank Rider at ADHS/DBHS for prior approval. You may contact Frank Rider at 602 364-4558.

Important Reminders . . .

AHCCCS Pended Encounters

Reminder: AHCCCS is now targeting April 2004 to begin processing new encounters. Since November 2003, they have only been processing "recycled" pended encounters (records that have not been changed online or processed in the Deletion/Override file).

Batch Eligibility Verification

The 270/271 transactions are now available on the WEB for batch client eligibility verification. AHCCCS requests that everyone test the new transaction with them before attempting to use the new process. To arrange for testing please call (602) 417-4451 or send an email to isdcustomersupport@ahcccs.state.az.us.

AHCCCS Encounters Error Codes

Z575 – Date of Service Already Billed on an Outpatient from Different Health Plan

Encounters are pending because the admit hour on an inpatient encounter is before the discharge hour on a competing encounter and cannot be overridden. Generally, this is a result of two encounters for one service submitted by two plans. Contact the other plan to determine if there are overlaps in dates of service; and who should have paid for the service or how much of the service. If you need further assistance, contact your technical assistant.

This one error accounts for 40.00% of the pended encounters at AHCCCS.

V Codes

The following V codes may be used as a primary diagnosis for all encounters/claims, ***except*** for inpatient hospitalization/Level I facilities. Please refer to the ICD9 coding book for a complete listing:

V15.81	Non-compliance with medical treatment	V61.49	Other health problems in family
V61.0	Family disruption	V61.9	Unspecified family circumstances
V61.10	Marital conflict, partner conflict	V62.2	Other occupational circumstances or maladjustment (career choice problem, dissatisfaction with employment)
V61.11	Counseling for perpetrator of spousal and partner abuse	V62.3	Educational circumstances (Dissatisfaction with school environment, educational handicap)
V61.20	Concern about behavior of child, Parent-child conflict	V62.4	Social maladjustment
V61.21	Counseling for victim of child abuse (child battering, child neglect)	V62.81	Interpersonal problems not elsewhere classified
V61.22	Counseling for perpetrator of parental child abuse	V62.82	Bereavement, uncomplicated
V61.29	Other family circumstances (problem concerning adopted or foster child)	V62.83	Counseling for perpetrator of physical/sexual abuse
V61.3	Problems with aged parents or in-laws	V62.89	Other life circumstance problems or phase of life problems
V61.41	Health problems within family, alcoholism	V62.9	Unspecified psychosocial circumstances

Important Definitions for Corporate Compliance

Health Care Fraud and Abuse Control Account (Section 1817 of the Social Security Act) was established within the Medicare Part A Trust Fund and funds activities relating to the cost of administering and the operation of the health care fraud and abuse control program. In addition to federal appropriations, the account will receive a portion of the funds penalties and fines recovered from those activities. It is estimated $240,558,320 in fiscal year 2004, will be recovered and is up significantly from the $104,000,000 in recovered fiscal year 1997.

Office of Program Support Staff

If you need assistance, please contact your assigned Technical Assistant at:

Michael Carter	NARBHA PGBHA	(602) 364-4710
Eunice Argusta	CPSA-3 CPSA-5 Gila River Navajo Nation Pascua Yaqui	(602) 364-4711
Javier Higuera	Excel Value Options	(602) 364-4712

AHCCCS Pended Encounter File Format Change

As discussed in the RBHA/IT meeting on 3/11/04, the data types of some of the fields will be changing from text to numeric and leading/trailing spaces will be removed from text fields. The order of the fields will remain the same. This will assist the RBHAs in researching and working the pends. OPS is targeting April 2004 for this change to the pend files.

Field #	Name	Type	Size
1	CRN	Text	14
2	ICN_NUMBER	Text	11
3	LINE_NUMBER	Text	2
4	F_NAME	Text	10
5	M_NAME	Text	1
6	L_NAME	Text	15
7	INTAKE_DATE	Date/Time	mm/dd/yyyy
8	CLOSURE_DATE	Date/Time	mm/dd/yyyy
9	SMI_FLAG	Text	1
10	ERROR_CODE_1	Text	6
11	ERROR_CODE_2	Text	6
12	ERROR_CODE_3	Text	6
13	CLIENT_ID	Text	10
14	PROCEDURE_CODE	Text	5
15	RBHA_ID	Text	2
16	BHS_PROV_ID	Text	10
17	AHCCCS_PROV_ID	Text	10
18	SVC_START_DATE	Date/Time	mm/dd/yyyy
19	SVC_END_DATE	Date/Time	mm/dd/yyyy
20	SVC_TYPE	Text	1
21	UNITS	Double	10(9).99
22	PATIENT_STATUS	Text	2
23	BILL_TYPE	Text	3
24	NDC_CODE	Text	11
25	NET_PAID	Double	10(9).99
26	SPECIAL_NET_VALUE	Double	10(9).99
27	FORM_TYPE	Text	10
28	MOTHER_ICN	Text	11
29	ALLOWABLE_CHARGE	Double	10(9).99
30	EDS_ADD_DATE	Date/Time	mm/dd/yyyy
31	ADMISSION_DATE	Date/Time	mm/dd/yyyy
32	PRIOR_AUTH	Text	6
33	DIAGNOSIS_CODE	Text	6
34	ADMISSION_TYPE	Text	1
35	OTHER_INSURANCE	Text	1
36	OTHER_INS_PAYMENT	Double	10(9).99
37	MEDICARE_ALLOW	Double	10(9).99
38	MEDICARE_DEDUCTABLE	Double	10(9).99
39	MEDICARE_PAYMENT	Double	10(9).99
40	DISPENSE_QTY	Long Integer	10(9)
41	REFILL_NBR	Long Integer	10(9)
42	REFILL_AUTH	Long Integer	10(9)
43	RX_ORDER_DATE	Date/Time	mm/dd/yyyy
44	ADMISSION_HOUR	Long Integer	10(9)
45	ADMISSION_SOURCE	Text	1
46	DISCHARGE_HOUR	Long Integer	10(9)
47	PHYSICIAN	Text	10
48	OCCURANCE_DATE	Date/Time	mm/dd/yyyy
49	OCCURANCE_CODE	Text	2
50	MED_PROC_CODE_MODIFIER	Text	2
51	REVENUE_CODE	Text	4
52	PLACE_OF_SVC	Text	2
53	DUP_OVERIDE	Text	1
54	ADJUSTMENT_FLAG	Text	1
55	PEND_DAYS	Double	10(9)
56	SANCTION_DATE	Date/Time	mm/dd/yyyy

Billing Questions …

Methadone Administration

Q May the code H2010 HG, for the dosing of methadone be used, even though it does not take the full 15 minutes allowed to pour the methadone in a cup and give it to the client?

A Yes, the code H2010 (Comprehensive Medication Services, per 15 Minutes) with procedure code modifier HG (Opioid Addiction Treatment Program) may be used for the dosing of methadone, even though a full 15 minutes is not taken to do this. Please note that only one unit is allowed for this procedure, as ***more*** than a 15-minute increment should ***not*** be necessary.

Data Validation Study CY20, Part 3

After the Data Validation Analysts have coded and matched the medical records to an encounter and have assessed each of the errors, AHCCCS prepares their preliminary report. The preliminary report is sent to ADHS/DBHS for distribution to the appropriate RBHA for review. The RBHA should review the preliminary findings to verify the correctness of the errors listed.

The review should include comparisons to data from the:

- Medical Records
- AHCCCS and ADHS/DBHS eligibility records
- AHCCCS coverage of the service provided
- AHCCCS provider registration
- Other data sources, as applicable

Once the preliminary report is reviewed, the RBHA will determine if any challenges will be submitted. A challenge must be submitted to AHCCCS within 30 days from the date of the letter to ADHS/DBHS. When the preliminary letter is sent to the RBHA, they are informed of the timeframe in which to have their challenge back to ADHS/DBHS.

User Access Request Forms

The Office of Program Support Services must authorize all requests for access to CIS, Office of Human Rights, Office of Grievance and Appeals, Issue Resolution System, and PMMIS (AHCCCS) databases. In order to obtain access to any of these databases, please fax or mail a copy of the appropriate User Access Request Form and User Affirmation Statement to Stacy Mobbs at (602) 364-4736. For questions or more information, please contact Stacy Mobbs by telephone at (602) 364-4708 or by e-mail at smobbs@hs.state.az.us.